

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

APPLICATION INFORMATION FORM

ATTENTION

IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 working days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925**. The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: <http://www.drl.state.wi.us>. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days of receipt of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: <http://www.drl.state.wi.us>. Look under "Business/Professional License Lookup" for your official credential number and grant date.

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MEDICAL EXAMINING BOARD

APPLICATION FOR TEMPORARY CAMP PHYSICIAN TO PRACTICE MEDICINE AND SURGERY

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK ☐ Your name and address are available to the public.
☐ Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Daytime Telephone Number
____ month ____ day ____ year	(____) ____ - ____

Ethnic/gender status information is optional. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

BEGINNING DATE OF PRACTICE IN WISCONSIN _____ LOCATION _____

ECFMG EXAM TAKEN	CERTIFICATE ISSUED	CERTIFICATE NO.	DATE ISSUED
____ YES ____ NO	____ YES ____ NO	_____	_____
SPECIALTY BOARD CERTIFICATIONS		DATE CERTIFIED	

What specialty do you practice at the present time? _____

I AM LICENSED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

APPLICATION FEE: (Make check payable to Department of Regulation and Licensing and attach to application).

For Receipting Use Only

____ \$122.00 Initial Credential Fee
____ \$ 57.00 State Law Exam
\$179.00 Total fee attached

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Notarized copies of an **original wall certificate and a current registration card** to practice medicine & surgery in another jurisdiction of the United States or Canada.

A letter requesting the applicants services from a camp organization or other recreational facility of the State of Wisconsin.

Physician Profile Data report **from** the American Medical Association or American Osteopathic Association.

Disciplinary Inquiry report **from** the Federation of State Medical Boards (Form #1445).

Wisconsin Statutes and Rules Examination Booklet and answer sheet.

Conviction & Pending Charges Form if applicable.

IMPORTANT:

Application for licensure must be approved by two members of the Medical Examining Board prior to issuance of a license.

Documents received for this locum tenens license are not transferable to a permanent medicine and surgery license application file.

PROFESSIONAL EDUCATION:

School Name	Location (City, State, & Country)	Degree	Date of Graduation (month/day/yr)

POST GRADUATE TRAINING AND ACTIVITIES: Outline in chronological order all activities from the date of graduation from medical school to the present time. **Must include professional and non-professional activities. All time and dates must be accounted for.**

NAME OF HOSPITAL OR CLINIC

LOCATION
City, State, & Country

DATES (from - to)
(Month/Year)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed to pass any state board examination, national board examination, USMLE or FLEX examination? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, including status of the charge and the location of court. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction court, and penalty. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and, if applicable, list name, address and phone number of your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
10. Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Regulation & Licensing

For the purpose of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures with or without the use of aids or devices, such as corrected lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

	<u>YES</u>	<u>NO</u>
14. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
15. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
17. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/>	<input type="checkbox"/>
20. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Regulation & Licensing

AFFIDAVIT OF APPLICANT (Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

Signature of Notary Public

S E A L

Date Commission Expires

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth _____ _____ _____
 month day year

- -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996

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DISCIPLINARY INQUIRIES REPORT

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

CAMP

**APPLICANT MUST COMPLETE THIS FORM AND FORWARD TO THE FEDERATION
OF STATE MEDICAL BOARDS AT THIS ADDRESS:**

FEDERATION OF STATE MEDICAL BOARD, INC.
FEDERATION PLACE
P.O. BOX 619850
DALLAS, TX 75261-9850

Attention: State Board Inquiries

The State of Wisconsin requests a Board Action Search concerning the following individual:

Practitioner's Name	(Last, First, Middle)	Degree
<hr/>		
Date of Birth (month/day/year)		
<hr/>		
Medical School		
<hr/>		
Year of Graduation		
<hr/>		
Social Security Number		
<hr/>		
ECFMG #		
<hr/>		
Practitioner's Signature: <hr/>		

FEDERATION OF STATE MEDICAL BOARDS

The State of Wisconsin requests a disciplinary search concerning the above individual. Please mail the response to the following address:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#1445 (Rev. 03/03)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing

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REQUEST FOR PHYSICIAN PROFILE DATA

MEDICAL EXAMINING BOARD

FEES:

AOA Members - No Charge
Non-Members - \$20.00

**APPLICANT: PLEASE COMPLETE THIS FORM AND FORWARD TO THE AMERICAN
OSTEOPATHIC ASSOCIATION AT THIS ADDRESS:**

American Osteopathic Association
Physicians' Biographic Records
142 East Ontario St.
Chicago IL 60611-2864
800-621-1773, Ext. 8145
FAX: (312) 202-8206
AOA Website (www.aoa-net.org)

The **State of Wisconsin** requests a physician profile concerning the following individual:

NAME

DAYTIME PHONE NUMBER

ADDRESS

DAYTIME PHONE NUMBER

CITY, STATE AND ZIP

YEAR OF GRADUATION (from Med. Sch) DEGREE

DATE OF BIRTH

E.C.F.M.G. NUMBER

SOCIAL SECURITY NUMBER

AOA NUMBER

Physician's Signature

Date

ATTENTION: AMERICAN OSTEOPATHIC ASSOCIATION

Please mail the response directly to the Wisconsin Medical Examining Board at the following address:

Department of Regulation & Licensing
Medical Examining Board
PO Box 8935
Madison WI 53708

American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State St
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through **AMA ePhysician Profiles** located at <http://www.ama-assn.org/AMAPhysicianProfiles>. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30am - 4:45pm CT.

*****Join or renew your AMA membership today---call 800-AMA-3211*****

Indicate AMA Membership Status: _____ Member Physician _____ Nonmember Physician

Membership Type	Standard Mail Service* (within 10 business days)	Express Service* (within 5 business days)
AMA Member Physician	No charge	\$6 per profile
Nonmember Physician	\$26 per profile	Not available

**Prices are subject to change without advance notice.*

Credit card payment is preferred as check payments may extend processing time. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 60610. Orders faxed to the AMA must include credit card information for billing purposes.

____ VISA ____ American Express ____ MasterCard Charge Amount: \$ _____

Credit Card Number _____ Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address: _____

Approval Signature _____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____
NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

Physician Name (first, middle, last, suffix) _____

Place of Birth _____ Date of Birth ____/____/____ Social Security Number _____

E-mail Address _____ Medical Education Number (optional) _____

Preferred Mailing Address _____

City, State, Zip Code _____ Telephone Number (____) _____ - _____

The above address is my OFFICE _____ HOME _____ OTHER _____

If address is home or other, please complete this section.

Primary Office Address _____

City _____ State _____ Zip Code _____ Office Telephone Number (____) _____ - _____

Part 3: Medical Education and Other Information

Medical School of Graduation _____

Year of Graduation _____

DEA Number _____

ECFMG Number _____

Residency TrainingResidency Training (institution/hospital name, location, and years) _____

_____**Hospital Admitting Privileges**

Hospital Name _____

City/State _____

_____**Group Practice Affiliation(s)**

Group Practice Name _____

City/State _____

_____**Physician Agreement****Agreement must be signed in order to process your request.**

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X _____
Signature_____/_____/_____
Date

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a \$6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip) _____

Mail To Address (if different) _____

Date of Birth	Social Security Number
_____ month day year	_____ Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____
2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE

DATE

CITY/STATE

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED
☐ ☐ _____
Did you successfully complete the program? ☐ ☐ _____
Please attach the certificate of completion/discharge summary.

- (Check all that apply)
4. Have you ever been sentenced to: YES NO MO/YR COMPLETED
☐ Probation ☐ ☐ _____
☐ Parole ☐ ☐ _____
☐ Ordered to pay restitution ☐ ☐ _____
Did you successfully complete one of the above as ordered by the court? ☐ ☐ _____

If you are **currently** on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **pending**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<u>PENDING CHARGE</u>	<u>DATE OF ARREST</u>	<u>LOCATION OF ARREST (city/state)</u>
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Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

Signature _____	Date _____
-----------------	------------

Signed and sworn before me this _____ day of _____, 20 _____.

Signature of Notary Public _____	Date _____
----------------------------------	------------

My commission (is permanent) _____ expires _____.

SEAL

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NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.^a An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at <http://www.legis.state.wi.us/rsb/code/rl/rl.html> and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at <http://www.drl.state.wi.us/> under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

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APPLICATION PACKET ADDENDUM (INTERNET)

MD and DO Temporary Camp Physician application packet

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

PLEASE PRINT OR TYPE

Full Name

Daytime Phone Number

Street Address

PO Box

City, State, Zip

Thank you.

#2612 (4/03)